

BENEFITS AND BARRIERS TO BEHAVIORAL HEALTH INTEGRATION IN AN ADOLESCENT COMMUNITY HEALTH SETTING

by

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ABSTRACT

Behavioral health services, such as the counseling and treatment of mental health and substance abuse issues, are typically outsourced from primary care to mental health professionals; however, care is not coordinated between the referring and referred physician. The Affordable Care Act (ACA) emphasizes the need to improve coordination of health care and mental health services through various incentives, and the legislation stresses the importance of integrating behavioral health and primary care services in order to better manage population health and reduce health care spending (Croft & Parish, 2013).

Many states, including North Carolina (N.C.), have listed behavioral health and primary care integration as a primary focus in their efforts to reduce cost, improve quality, increase accessibility to health care services, and prevent overutilization of emergency care services. In June 2013, the Teen Wellness Center in Gaston County, N.C., a state-funded, adolescent-focused community health center, aimed to determine the benefits and barriers to integrating behavioral health services into their currently offered services. The Teen Wellness Center (TWC) serves as a case study to determine the feasibility of integrating behavioral health services within similar types of health care facilities.

After reviewing available guidance, lessons learned, and research, it was determined that the TWC's patient population demonstrated a need for access to and/or utilization of behavioral health services, and basic levels of collaboration would be fairly easily achievable. The extent to which the TWC can offer fully integrated services is, however, a longer-term consideration that requires large stakeholder approval, and likely, a visible leader to champion the effort.

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CHAPTER I

INTRODUCTION

Overview of Behavioral Health Services

The National Institute of Mental Health (NIMH) states that an estimated 26.2 percent of Americans ages eighteen and older, or approximately 58 million people, suffer from a diagnosable mental disorder each year (Milbank, 2010). Mental disorders such as depression, anorexia, post-traumatic stress disorder and more, are the leading causes of disability in the United States (U.S.) and Canada. Research shows that mental illness begins very early in life, with half of all lifetime cases beginning by age fourteen. Unlike most other chronic diseases, mental illness often begins in childhood and adolescence (Milbank, 2010).

Over half of all Medicaid beneficiaries with disabilities are diagnosed with a mental illness (Centers for Medicare & Medicaid Services [CMS], 2011). Health care costs can be as much as 75 percent higher for a person with a chronic disease and mental illness compared to those without a mental illness (CMS, 2011). Mental illness is three times as common among dual-eligible individuals – those individuals with both Medicare and Medicaid coverage – than Medicare-only individuals (CMS, 2011).

Dual-eligibles also have correspondingly higher healthcare costs. One in five dual-eligibles has more than one mental illness, which results in average spending of \$38,000, twice as high as the average dual-eligible population (CMS, 2011). However, most individuals with both physical and mental or behavioral health needs receive care within facilities that have little or no coordination or communication between providers, leading these individuals to receive

incomplete, duplicative or unnecessary care (CMS, 2011; Integrated Care Resource Center [ICRC], 2011).

As cited in Robinson and Reiter (2007), as many as 70 percent of primary care visits stem from psychosocial issues. While patients typically come to the appointment with a physical health concern, data suggest that behavioral health issues often underlie or initiate these visits. Research has shown that integrated care for depression doubles the rate of medication adherence (i.e., the rate at which patients stay on their prescribed medication and take it as indicated) compared to primary care treatment on its own (Williams, 2012).

Definitions

Behavioral Health Services

Behavioral health services are, broadly, services to treat “individuals at risk of, or suffering from, mental, behavioral, or addictive disorders” (Finch, Phillips, & the Center for Prevention and Health Services, 2005, p. 2). Services are typically focused on treating mental disorders and their symptoms, such as depression and suicidal thoughts, chemical dependency or risk-taking behaviors, such as promiscuity (PacifiCare Behavioral Health, 2001) through the use of mental health, psychiatric, marriage and family counseling, and addictions treatment (Finch et al., 2005). Within the U.S., behavioral health services are typically provided as specialty care, meaning patients are often referred to behavioral health specialists who provide care outside of the primary care setting (Milbank, 2010).

Integrated Care

Integrated care or collaborative care are often used interchangeably to describe the process by which health care professionals consider all of a patient’s health conditions in a holistic manner, instead of treating one specific acute condition (Milbank, 2010). Integrated care

more specifically refers to the inclusion of services within a single setting, whereas collaborative care typically refers to interaction between providers who work in separate settings (Milbank, 2010).

Behavioral Health Integration

Behavioral health integration is the “systematic coordination” of health care services, both physical and behavioral, according to the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions (2014). This means that mental health concerns are addressed along with physical health concerns within the same practice, and further or ongoing care needs are recommended for any presenting issue. When implemented in a manner consistent with evidence-based practice, integrated care increases overall care coordination among various health care professionals for a specific patient, which research has shown improves health outcomes and reduces costs (North Carolina Foundation for Advanced Health Programs, 2009).

Need for Improved Access to Behavioral Health Services

Several reasons have been cited for the integration of primary care and behavioral health services, most importantly the prevalence of mental health disorders and the treatment gap between the number of people with mental health problems and the significantly smaller number actually receiving treatment. Additionally, providing mental health services in primary care settings can reduce discrimination; increase cost-effectiveness of care; and improve outcomes, especially as many physical health problems are related to mental health problems (Milbank, 2010). More than two-thirds of individuals with mental illness have one or more chronic physical condition, such as high blood pressure, diabetes, heart disease, obesity, or asthma (SAMHSA-HRSA, 2014). These conditions, coupled with untreated mental or substance abuse issues lead

to, on average, earlier death and poorer quality of life than the general population (SAMHSA-HRSA, 2014).

A 2007 survey of community mental health centers (CMHCs) revealed limited capacity: two-thirds of CMHCs can screen for common medical problems; half can provide treatment or referral for those conditions; and only one-third provide some medical services on-site (Druss et al., 2008). Since primary care and mental health services are largely kept separate, mental health centers are unequipped to manage patients' holistic health needs.

An integrated program that saw 170 patients with mental illness reduced hospitalizations for mental health reasons, nights in detox, ER visits, and homeless nights significantly in one year (SAMHSA-HRSA, 2014). Clinical integration through affiliation and/or collaboration has also been a long-established goal of community health centers, which now provide primary care services to approximately 20 million mostly uninsured Americans (North Carolina Foundation for Advanced Health Programs, 2009). Health centers are expected to provide care to millions more as the ACA expands health care coverage to lower-income Americans, many of whom live in the medically underserved communities where health centers operate.

Types of Integrated Systems

National Behavioral Health Integration Programs

Partnerships among health centers, hospitals, and clinics have enabled health centers to expand and enhance the services they provide. For this reason, HRSA, the federal agency that oversees health centers, supports collaboration including the formation of provider networks for shared services and joint contracting arrangements that serve to assure patients obtain the full range of services they need. Experts have identified several common types of collaboration/integration including (The Commonwealth Fund, 2011, p. 19):

- Referral arrangements,
- Co-location arrangements: provider maintaining their own practice agrees to treat patients referred to them, but in the referring provider's location,
- Nonexclusive contractual arrangements: health centers and other providers jointly contract for the purchase or provision of services,
- Umbrella affiliation agreements: health centers remain independent of their partners, but agree to collaborate in planning and executing new programs under a binding affiliation agreement, and
- New health center sites, a particularly fast-growing area in which a non-health center health care provider essentially converts an existing non-health center primary care clinic(s) into a health center service site that meets all federal health center requirements and is governed and operated by an existing health center with partner input.

The arrangements suggested by HRSA align partially with other common definitions of integration levels. The Integrated Behavioral Health Project (2007) (run through the California Mental Health Services Authority [CalMHSA]) defines five levels of health care integration for mental and primary care services:

1. Minimal collaboration – separate systems, separate care settings; primarily referral-based with little to no communication.
2. Basic collaboration – separate systems and settings, but intermittent communication between settings regarding shared patients.
3. Basic collaboration on-site – separate systems but within the same care setting; physicians communicate with some frequency regarding shared patients.

4. Close collaboration in a partly-integrated system – shared systems (i.e., scheduling, medical records), shared care settings; regular face-to-face clinician communication regarding patients. Philosophy of patient management may not align amongst care providers.
5. Close collaboration in a fully-integrated system – shared systems and setting, frequent collaboration and communication among providers regarding patient needs.

Philosophy of patient management aligns amongst care providers.

Any minimal collaboration is considered better than none, but the Integrated Behavioral Health Project and HRSA both encourage higher levels of integration to have successful delivery of care and coordination of services. The ACA includes a number of provisions that provide support and incentives for states and health care providers to integrate primary care and behavioral health services (Croft & Parish, 2013). Integrated health services and greater care coordination is believed to play a major role in reducing health care spending and unnecessary waste in the health care system (e.g., unnecessary tests, hospitalizations, and/or readmissions) (SAMHSA, 2013).

North Carolina Initiatives

Within N.C., there are several statewide initiatives or resources that encourage the integration of physical and behavioral health services or provide these services. These include the ICARE Partnership and Community Care of N.C., as well as some of the state policies impacting the provision of services to teens.

ICARE Partnership. The ICARE Partnership (Integrated, Collaborative, Accessible, Respectful, and Evidence-based), part of Governor Perdue's behavioral health agenda in 2009 and an initiative of the North Carolina Foundation for Advanced Health Programs, was designed

to improve patient outcomes by increasing collaboration and communication between primary care and behavioral health providers. In addition, it encouraged increasing the capacity of both primary care practices to provide appropriate, evidence-based behavioral health services, and of specialty behavioral health providers, to screen and refer for physical illness (North Carolina Foundation for Advanced Health Programs, 2009).

Community Care of North Carolina. In 2010, North Carolina added an enhanced per member per month (PMPM) payment to its existing primary care case management PCCM program, Community Care of North Carolina (CCNC), to support integration of behavioral health services into the 1,400 primary care practices in CCNC networks across the State. The enhanced payment allowed each of the 14 CCNC networks to hire a psychiatrist and behavioral health coordinator to focus on integration at the local level (California Department of Health Care Services, 2009).

Within the CCNC program, the network mental health practitioners collaborate with local behavioral health systems to determine best practices for screening, counseling, and medication. They also engage with community stakeholders and external psychiatrists. The behavioral health coordinators within each CCNC network use data on patients to identify enrollees that could benefit from care management, as well help patients find the appropriate mental health or substance abuse providers, and help primary care providers coordinate behavioral health services (California Department of Health Care Services, 2009).

In addition, CCNC incorporated behavioral health notifications into an existing electronic care management tool to help identify patients in need of assistance (ICRC, 2011). An important result of integrated health care delivery for both patients and providers is the consolidation of all care information in one central database amongst a group of coordinated providers. For health

care providers, this can improve the ease of monitoring all health conditions a patient may have and to coordinate treatments so they do not interfere with other medications or treatment plans the patient has.

Healthy Youth Act. The Healthy Youth Act is a 2009 N.C. state law that was implemented in the state public school systems during the 2010-2011 academic year. The Act requires that each school system provide reproductive health and safety education that meets the guidelines put forth by the law. Though the law aimed to move reproductive education away from the abstinence-until-marriage curricula present in N.C. schools, it does not meet its original objective. The curricula is still abstinence-until-marriage, but now includes information on the benefits and risks of Food and Drug Administration (FDA) approved contraceptives (American Civil Liberties Union [ACLU], 2009). Since condoms are not FDA-approved, that excludes them from the parameters of the law. In addition, the Act also includes provisions for parents to review the health education curriculum and withdraw their child from instruction if they choose.

For more than four decades, counseling and treatment provided to minors for primary care services, including pregnancy, sexually transmitted diseases, substance abuse and other mental health issues, were not disclosed to parents or guardians of those receiving care (NC Health News, 2013). House Bill 693, filed April 2013 and withdrawn from the N.C. General Assembly in May 2013, would have made North Carolina the only state in the country to require teens under the age of 18 to be accompanied by either a parent or guardian – or have notarized parental consent – when seeking care for any of the sexual health or mental health services that previously did not require consent (WRAL, 2013). Though the bill was withdrawn from the House, it is possible that legislators may revise and resubmit a bill of this type in the future.

Minors' Rights Laws. Current minors' rights laws include protection for adolescents seeking care for reproductive health services and some mental health services that present a clear danger to the minor if left untreated, such as substance abuse, suicidal thoughts, and severe depression (North Carolina Department of Health and Human Services [NCHHS], 2011). These issues do not require parental approval to treat. However, because some mental health issues outside of the minors' rights laws require parental signature, provision of services is limited for those adolescents who feel uncomfortable speaking to their parents or cannot get parental support for seeking counsel or treatment.

Policies Impacting Behavioral Health Services through the Affordable Care Act (ACA)

The ACA was enacted to do three main things: expand access to health care services, improve quality of health care services, and reduce overall costs in the U.S. health care system (Rosenbaum, 2011). A major way that the ACA seeks to control or minimize costs while improving quality is through better coordinated care planning.

One provision of the ACA is the creation of accountable care organizations (ACOs), which seek to provide greater coordination of care through networks of doctors who share responsibility for a set patient population. These physician networks are incentivized to limit unnecessary spending and improve patient outcomes (Kaiser Health News, 2013). In addition, people receiving integrated care report higher quality of life, increased satisfaction with access to care, greater attention given to treatment preferences, and better continuity of care (i.e., seeing the correct doctors and receiving the correct treatment at the correct times) (National Council for Community Behavioral Health, n.d.).

Patient-centered medical homes are another new care delivery model that seeks to increase care coordination among providers, resulting in lower-cost, higher-quality health care.

The patient-centered medical home model includes a team of health care providers with collective responsibility for a patient's ongoing care. With a holistic orientation to care, patient-centered medical homes typically include collaboration, and affiliation or full staffing of at least one trained mental health professional within the practice.

Cost Implications

Studies of the cost-effectiveness of integrating behavioral and physical health services range in findings, largely due to variation in the severity of both mental and physical health needs of the population being served (Strosahl & Robinson, n.d.). Meta-analyses of research conducted on medical savings demonstrate a 20-30 percent decrease in overall costs per patient; some studies shows up to 70 percent savings in inpatient medical costs, but an increase in outpatient services reduces total savings (Strosahl & Robinson, n.d.)

An integrated program within Massachusetts General Hospital quantified annual hard savings of 7 percent among enrolled patients. In addition to hard medical cost savings of services received, the hospital found that mortality rates decreased 4 percent and readmissions decreased 20 percent (Partners HealthCare, n.d.). These findings demonstrate that the cost savings from integrating services extend beyond direct medical costs to include avoided costs and overuse of the health care system, as well as extended life expectancy.

In addition, fringe costs of non-treated mental health issues include lost productivity and time off work for both those suffering from mental illness and their caretakers. Research presented by the World Health Organization's (2003) quantified total U.S. mental health costs as \$148 billion; they suggest that indirect costs equal or exceed direct medical costs.

CHAPTER II

TEEN WELLNESS CENTER (GASTON COUNTY, N.C.) CASE STUDY

Gaston County Demographics and Description

Gaston County, N.C. is located in the south-central Piedmont of the state, and has a population of 208,000, representing roughly 2 percent of the state's population. Approximately one-quarter of the population is under 18 years old. While 81 percent of the population are high school graduates (compared to 85 percent in N.C.), only 18 percent have a bachelor's degree (compared to 27 percent in the state) (U.S. Census Bureau, 2014).

The city of Gastonia accounts for 71,000 of the 208,000 people in the county, approximately 34 percent. Of the fifteen municipalities in Gaston County, only three contain more than 10,000 people: Gastonia, Belmont, and Mount Holly.

Gaston County ranks 81st out of 100 in the state in terms of health outcomes, according to County Health Rankings & Roadmaps (2013). Gaston County residents reportedly average one additional day of poor physical health (in the past 30 days) and one additional day of poor mental health compared to N.C. as a whole. Gaston County also has poor indicators and outcomes in the areas outlined in Table 2.1. Gaston County Schools is the largest employer in the county and the ninth largest school district in the state, containing 55 schools (Gaston County Health Department, 2012).

Assessment Data Demonstrating Need

Community Health Assessment

In the 2011 State-of-the-County health report, the Gaston County Health Department identified three main priorities to improve health status in their community: reduce overweight

TABLE 2.1
COUNTY, STATE, AND NATIONAL HEALTH INDICATORS

Indicator	Gaston County, N.C.	State (N.C.)	National (U.S.)
Sexually Transmitted Diseases	427/100,000	441/100,000	92/100,000
Teen Birth Rate (age 15-19)	58/1,000	46/1,000	21/1,000
Excessive Drinking	13%	13%	7%
Preventable Hospital Stays	71/1,000 Medicare enrollees	63/1,000 Medicare enrollees	47/1,000 Medicare enrollees
Adult Smoking	27%	21%	13%
Children in Poverty	24%	25%	14%

Source: County Health Rankings & Roadmaps (2013)

and obesity; reduce teen pregnancy, STD transmission and HIV/AIDS; and prevent chemical dependency by reducing tobacco use and substance abuse. Both the second and third priorities were aimed at children and adolescents (Gaston County Health Department, 2011). In addition, 24 percent of adults in the area report binge drinking on at least one occasion within 30 days of the survey in 2010. More than half of survey respondents are former or current smokers; approximately 28 percent still smoke (Gaston County Health Department, 2011) (see Table 2.2).

Middle School/High School Students' Surveys

According to the Centers for Disease Control and Prevention (CDC, 2013b) Youth Risk Behavior Surveillance System (YRBSS) questionnaire distributed amongst Gaston County adolescents in 2013: 25 percent of middle school respondents (n=540) have had more than a few sips of alcohol; 6 percent (n=142) have offered, sold or given an illegal drug on school property; 6 percent (n=121) have taken a prescription drug without a prescription; and 9 percent (n=192) have smoked cigarettes in the past year (111 of whom tried to quit within the last twelve months).

Among high school-age respondents to the YRBSS (CDC, 2013b) questionnaire:

- 20 percent report riding in a car in the past 30 days that was driven by someone who had been drinking, 13 percent more than once;
- 17 percent have smoked in the past month;
- 5 percent have taken steroids without a prescription; 20 percent have taken a prescription drug without a prescription;
- 6 percent have tried cocaine;
- 19 percent have been given or bought illegal drugs on school property in the past year; and

TABLE 2.2**CHEMICAL USE AND DEPENDENCY, GASTON COUNTY ADULTS, 2007-2010**

Status of Adults Who Use Tobacco	2007 (%)	2008 (%)	2009 (%)	2010 (%)
Smoke everyday	20.2	22.2	15.9	18.2
Smoke some days	4.6	6.9	7.8	9.4
Former smoker	25.2	22.9	25.4	24.0
Never smoked	50.0	48.0	51.0	48.3
Adults Who Currently Use Chewing Tobacco or Snuff	2007 (%)	2008 (%)	2009 (%)	2010 (%)
Every day	13.9	7.7	1.8	2.0
Some days	12.6	8.7	1.7	3.5
Not at all	73.6	83.6	96.5	94.5
Number of Times Adults Had Five or More Drinks on an Occasion (in past 30 days)	2007 (%)	2008 (%)	2009 (%)	2010 (%)
None	63.2	61.4	67.8	76.1
Once	9.1	7.6	9.7	11.8
Twice	13.0	4.8	7.4	4.9
3-7 times	13.2	15.8	11.0	4.6
8-30 times	1.5	10.5	4.2	2.6

Source: Gaston County Health Department (2011)

- The majority of students who have drunk alcohol or smoked marijuana started when they were between 11 and 16 years old.

According to the 2012 Gaston County Community Health Assessment, illegal drug use is the top ranked problem for each of the high school districts in the county (see Table 2.3). The second highest concern is obesity, the third and fourth concern for each district are prescription drug abuse and alcohol abuse (though districts vary on whether alcohol or prescription drugs are of higher concern in their community).

In 2008, ranked health issues for Gaston County included two mental health issues within the top ten (alcohol and substance abuse, mental illness). By comparison, in 2012, four of the top ten ranked health issues were mental health-related issues including: illegal drug use (number two), alcohol abuse (number four), prescription drug abuse (number five), and mental health (number nine) (see Table 2.4) (Gaston County Health Department, 2012).

Although depression does not appear on the ranked issues list above, 76 percent of middle school respondents to the YRBSS questionnaire reported feeling sad. Nearly 11 percent (n=253) of those who reported feeling sad were not sure who they would speak to about their feelings. Almost 300 middle school respondents (12.8 percent) report they have made a plan for how they would kill themselves at least once in the past (CDC, 2013b).

Amongst high school students, 54 percent (n=1134) stated they have seen other students being bullied at school during the past year. More than one-quarter (26 percent; n=539) of high school respondents reported feeling sustained sadness (two or more weeks) in the previous year that stopped him or her from doing some of their usual activities. Almost 500 students (n=468 or 22 percent of high school respondents) reported attempting suicide in the past year, 115 of whom

TABLE 2.3
RANKED HEALTH CONCERNS BY HIGH SCHOOL DISTRICT

Rank	Ashbrook	Bessemer City	Cherryville	East Gaston	Forestview	Hunter Huss	North Gaston	South Point
1	Illegal drug use (83.4%)	Illegal drug use (85.6%)	Illegal drug use (83.9%)	Illegal drug use (82.1%)	Illegal drug use (83.3%)	Illegal drug use (85.5%)	Illegal drug use (85.7%)	Illegal drug use (83.9%)
2	Obesity (83.1%)	Obesity (83.8%)	Obesity (82.3%)	Obesity (82.0%)	Obesity (82.6%)	Obesity (83.2%)	Obesity (84.2%)	Obesity (81.7%)
3	Alcohol abuse (77.0%)	Alcohol abuse (78.8%)	Prescription drug use (78.2%)	Alcohol abuse (76.6%)	Prescription drug use (77.3%)	Alcohol abuse (79.1%)	Alcohol abuse (79.5%)	Alcohol abuse (77.4%)
4	Prescription drug use (76.3%)	Prescription drug use (78.8%)	Alcohol abuse (77.6%)	Prescription drug use (76.2%)	Alcohol abuse (76.8%)	Prescription drug use (78.4%)	Prescription drug use (79.2%)	Prescription drug use (77.4%)
5	High blood pressure (76.1%)	High blood pressure (76.7%)	Teen pregnancy (75.7%)	Teen pregnancy (74.7%)	Teen pregnancy (74.7%)	High blood pressure (76.9%)	High blood pressure (76.9%)	Teen pregnancy (74.5%)

Source: Gaston County Health Department (2012)

TABLE 2.4**TOP RANKED HEALTH ISSUES FOR GASTON COUNTY, N.C. ADOLESCENTS**

Rank	2008	2012
1	Obesity	Obesity
2	Alcohol and substance abuse	Illegal drug use
3	Teen pregnancy	Teen pregnancy
4	Motor vehicle accidents	Alcohol abuse
5	Lack of health care for the uninsured	Prescription drug abuse
6	High blood pressure	High blood pressure
7	Mental illness, including depression	Diabetes
8	Diabetes	Heart disease
9	Learning and developmental problems	Mental health
10	Cancer	Cancer

Source: Gaston County Health Department (2012)

had their attempt result in an injury needing to be treated by a health care provider (CDC, 2013b).

It was reported in the 2012 Community Health Assessment that Partners Behavioral Health Management provides mental health, developmental/disability issues and substance abuse services through an integrated network in the community. It is believed that the availability of this resource is the reason only 8.8 percent of survey respondents felt they did not have access to mental health services (see Table 2.5). Perception of access is important for those who may proactively seek help for behavioral health issues.

The recent community health assessment and results from the YRBSS questionnaires indicate that there is a real behavioral health problem exhibited in Gaston County adolescents, both in terms of substance abuse and mental health. Although many adolescents state they have access to health care services, it does not appear that current programs are adequately curtailing substance use or abuse or deterring risky behaviors.

Background of the Teen Wellness Center (Gaston County, N.C.)

The Gaston County Teen Wellness Center is located within the Gaston County Health Department in Gastonia, N.C. As such, the Teen Wellness Center (TWC) receives state funding to provide services to the area. The TWC's main facility is within the county's main health department, but there are three other TWC locations within the county: Highland, Bessemer City, and Cherryville.

The TWC is currently the only health care facility directed solely toward adolescent primary care and reproductive health services in Gaston County, N.C. Nearby Charlotte, N.C., has additional resources, including the Teen Health Connection, which is similar to the TWC and recently integrated counseling for mental and behavioral health issues into its primary services.

TABLE 2.5

ACCESS TO HEALTH RESOURCES BY COMMUNITY HEALTH ASSESSMENT

RESPONDENTS

	Are you able to get the service you need?					
Service	Response	Community	Low-Income	Leaders	High School	All Respondents
Personal doctor	Yes	95.5%	77.0%	99.7%	79.4%	87.4%
	No	3.9%	20.4%	0.0%	6.0%	5.6%
	N/A	0.6%	2.6%	0.3%	14.7%	7.1%
Medical specialist	Yes	84.9%	63.7%	97.3%	65.7%	76.1%
	No	8.3%	25.8%	1.7%	10.5%	9.8%
	N/A	6.8%	10.5%	1.0%	23.8%	14.1%
Health care for infants and children	Yes	42.3%	32.3%	46.0%	51.7%	46.3%
	No	3.3%	3.6%	1.8%	8.3%	5.4%
	N/A	54.4%	62.5%	52.3%	40.1%	48.3%
Health care for pregnant women	Yes	28.3%	18.2%	30.4%	45.0%	35.3%
	No	2.5%	5.2%	1.8%	9.7%	5.9%
	N/A	69.2%	76.0%	67.9%	45.8%	58.8%
Health care for the elderly	Yes	34.1%	34.4%	39.9%	44.8%	39.5%
	No	5.2%	6.3%	1.8%	9.1%	6.7%
	N/A	60.7%	58.9%	58.4%	46.6%	53.8%
Cancer screening services	Yes	70.6%	53.6%	79.7%	46.4%	59.3%
	No	6.0%	13.5%	1.4%	10.7%	8.2%
	N/A	23.4%	32.3%	18.9%	43.4%	32.5%
Cancer treatment services	Yes	47.2%	29.2%	49.5%	44.8%	45.0%
	No	4.8%	12.0%	1.8%	10.2%	7.5%
	N/A	48.0%	57.8%	48.8%	45.1%	47.5%
Dental care	Yes	84.8%	64.6%	93.8%	77.5%	81.0%
	No	10.9%	24.5%	3.8%	6.1%	9.0%
	N/A	4.3%	10.4%	2.4%	16.3%	10.0%
Mental health, including depression	Yes	47.7%	50.5%	50.0%	48.9%	48.7%
	No	6.9%	15.1%	2.5%	10.8%	8.8%
	N/A	45.4%	33.3%	47.5%	40.3%	42.4%
Learning and developmental problems	Yes	21.2%	25.0%	26.6%	45.0%	33.0%
	No	7.0%	11.5%	3.2%	11.1%	8.8%
	N/A	71.8%	63.0%	70.2%	43.8%	58.2%
Care for alcohol abuse	Yes	19.5%	21.9%	25.2%	40.3%	29.9%
	No	4.5%	7.8%	2.8%	12.0%	8.0%
	N/A	75.9%	69.8%	71.3%	47.5%	62.1%
Care for drug abuse	Yes	19.1%	23.4%	24.1%	39.9%	29.6%
	No	5.0%	6.8%	3.2%	12.8%	8.5%
	N/A	76.0%	68.8%	72.0%	47.1%	61.9%

Source: Gaston County Health Department (2012)

The Teen Wellness Center accepts all types of private insurance, self-pay, and Medicaid. Depending on the type of integration model chosen, there may be added complexity for the Billings and Claims department to reconcile how claims are made for different services (primary care and behavioral health). Claims are processed by billings and claims professionals who work within the Gaston County Health Department.

There are several TWC locations within Gaston County making it easily accessible to most adolescents by car. The Health Department, where the TWC is located, has a stop on a local bus route, but traveling there by bus from different parts of the county could be difficult and time-consuming. A Medicaid access bus serves the local community and will pick up Medicaid-eligible adolescents and drive them to the Center to receive services.

Local public schools are largely conservative about the way they teach health education, even since implementation of the Healthy Youth Act; as a result, the TWC has had difficulties working with the local public school system to educate students about the services available at the Center. The TWC primarily markets its services by word-of-mouth or through programs put on in the area malls and other non-school locations.

Staff advocates within the TWC recently participated in a Women's Integrated Systems for Health (WISH) Academy program with the University of North Carolina at Chapel Hill Gillings School of Global Public Health to receive training on ways to improve the health of reproductive-age women through integrated physical and mental health solutions. This program spurred TWC staff to investigate opportunities or barriers to integrating behavioral health/mental health services within their own facility.

CHAPTER III

RESULTS

Challenges and Barriers to Integration

Barriers to clinical integration and coordination of care include basic logistical issues, such as the complexity of establishing partnerships between facilities and sharing patient information that has historically been separate. Information sharing may be difficult if providers do not share facilities and medical record systems. With the proliferation of electronic medical records (EMRs) and other advanced data analytics systems within health care organizations, information sharing may become easier, though organizations using disparate technological systems may still have difficulties accessing data across facilities.

Additionally, confidentiality laws pertaining to substance abuse and mental health are typically stricter than those pertaining to primary care or physical health (Milbank, 2010). However, sharing information for the purpose of care coordination is allowed under HIPAA without formal consent. Lastly, payment and reimbursement may be divided for services, complicating administrative processes.

State budgets have been historically tight during the recent U.S. recession. Since the TWC is government-funded, finding additional funding to hire a mental health practitioner or otherwise integrate systems with an external mental health provider may be difficult. There is funding available from several Federal sources for these types of integrated health care programs, as part of the ACA, which may be a financial resource for the TWC (SAMHSA, 2013).

A checklist was prepared as part of a business plan developed for the TWC that outlines some of the feasibility issues and barriers commonly described by other facilities that converted to an integrated model (Appendix). This outline gives TWC directors and health department officials an easy way to go through the likely issues they will need to consider as they decide to integrate services.

Opportunities for Integrated Services at the Teen Wellness Center

Opportunities are seen in four key areas: consent structure, tightening referral arrangements, affiliated providers, and rotating, embedded mental health providers. The Teen Health Connection, in Charlotte, N.C., serves as a case study for the TWC, since it is geographically proximate to the TWC and it has recently integrated behavioral health counseling into its primary care services. During initial visits, mental health services can be provided to teens without parental signature. However, future visits need parental signature. The advantage to this consent structure is the ability to provide services to the teen while also giving the teen time to speak with his or her parents. It will still limit some teen participation in services due to embarrassment or unwillingness to involve his or her parents.

The TWC currently has a list of external, non-affiliated mental health providers to whom they refer patients. The relationship the TWC has with external mental health providers could be considered “minimal collaboration” or a “referral arrangement.” Though this level of collaboration gives TWC patients a next step in their care plan, it has several limitations, including: the TWC cannot send reminders or follow-up with its patients regarding their visit to a mental health provider; the TWC does not have access to patients’ records from their mental health visits; and TWC providers cannot collaborate with mental health providers regarding patients’ optimal long-term treatment plan.

The next step in integration (basic collaboration at a distance) – partnering with external mental health providers the TWC refers patients to – would be achievable with little to no additional time or resources. This option would increase the TWC’s access to information about shared patients and give TWC providers more input in the overall care plan; however, patients would still need to be proactive in scheduling their referral appointments with mental health providers. In addition, patient records would remain completely separate.

Space constraints within the TWC/health department facility in Gastonia will limit the TWC’s ability to bring a team of mental health providers on-site to share the facility while maintaining separate systems (basic collaboration on-site). It is unlikely that a single mental health practitioner would be willing to have their own practice within TWC facilities without sharing systems with the TWC.

Another opportunity for integration, which resolves the issue of disparate systems and facilities, is to hire one (or more) mental health practitioners to hold rotating hours within the TWC county facilities. This would allow for on-site mental health referrals so that patients can make their appointment at the time of their first primary care visit (or see the mental health provider on the same day). It would also allow for integrated patient records systems and more shared decision-making between primary care and mental health providers within the TWC.

This option, a form of close collaboration in a partly-integrated system, would require an investment for one or more full-time positions (rotating between facilities) for mental health providers and some additional training for administrators in scheduling and billing. However, for a fairly small initial and ongoing investment, it resolves many of the issues the TWC has encountered as it treats patients in need of mental health care. In addition, comparatively to becoming fully integrated, which would require a much more significant investment in

expanding the facility space and embedding a mental health team within each facility, this option is the most cost-effective while providing a truly integrated, collaborative system.

CHAPTER IV

DISCUSSION

Lessons Learned

The Teen Wellness Center is confronted with similar issues as other health centers that seek to integrate primary care and behavioral health services within their facilities. These issues are exacerbated in some ways due to the demographics of the TWC. The TWC is different than many case studies examined who have successfully integrated services, because the TWC is both a community health center, and services rendered must be agreed upon by county health commissioners and the state government. In addition, services are provided to minors exclusively.

Most of the barriers discovered through public sources and case studies (SAMHSA-HRSA, 2013) were logistical in nature. Facilities that have integrated services encountered issues with the funding of mental health staff, coordinating billing and payment for more diverse services, developing new intake forms, and creating care pathways for patients that demonstrate both physical and mental health issues.

Gaston County Schools have not been historically open to sexual education programs that promote methods outside of the abstinence-until-marriage curricula, which has significantly limited the TWC's ability to work with students and gain recognition of their center with adolescents in the region. This is likely an issue that would present difficulty to the TWC in gaining awareness of new behavioral health services they would offer if they decide to integrate services.

N.C. as a whole, though it has been fairly progressive in promoting integrated health services generally, has embraced more restrictive minors' rights than other states. Although some adolescents may choose for a parent to accompany them to the TWC, especially among those that have not yet reached legal driving age, parental consent or accompaniment is a limiting factor for many teens who would otherwise seek counsel or treatment on their own.

Since the TWC is part of the Gaston County Health Department, the decision to integrate services cannot be made without approval by the health department, county commissioners, and possibly, the state government. Stakeholder approval will depend on a number of actual and political factors and may take a considerable amount of time to achieve.

Need for Leadership

One main key to success mentioned in various case studies examined is the need for a leader or champion to emerge. In many cases, this champion was a provider within the facility who felt strongly about the advantages of integrated services. The TWC currently has staff champions; however, due to the number of stakeholders who need to approve integration, it may behoove the center to find a champion higher up. This could be a county commissioner or their state representative.

Social Ecological Field Model Application to Integrating Services

Using the Social Ecological Model of health as framework for considering overall readiness to integrate, the barriers to integration can be considered as individual and interpersonal, organizational, and community and policy-level (CDC, 2013a). Each one will be briefly discussed.

Individual and Interpersonal Factors

Individual and interpersonal factors impacting the success of integrating services within the TWC include the willingness and interest of those working within the TWC and the Gaston County Health Department to go through the steps of integration. A business plan was created to outline the steps and considerations for integrating services, which the TWC can present to other stakeholders to gain buy-in. Due to this initial step in consideration of integration, it seems administrators are engaged in the concept of behavioral health integration.

An individual from TWC will likely need to take ownership of the integration process to continue progress. Given staffing constraints, it may be difficult for a current administrator to take on this additional responsibility. Individual and interpersonal factors also include the willingness of adolescents within the community to seek counseling or treatment for behavioral health issues, as well as the personal beliefs of the county health commissioners who will need to approval integration.

Organizational Factors

Organizational factors include billing and claims management, scheduling and coordination of providers, and the affordability of hiring mental health providers. The case study primarily considers organizational factors influencing the decision to integrate services. Due to the nature of the TWC's patient population being minors, this may bring in a set of difficulties that do not exist within community health centers that provide services to an adult population or one that includes both adults and minors.

Additionally, since the TWC is state-funded, administrators will need a hierarchy of stakeholders to embrace and approve the decision to integrate services before proceeding. Stakeholders include the health department, county commissioners, and possibly, the state

legislature (to sign-off on funding). There are more steps necessary for the TWC than other health settings to gain agreement to pursue an integrated care model, which may influence the decision to move forward on the part of TWC administrators.

Community and Policy Level Factors

A major community-level factor impacting the TWC's decision to move forward with integration, which is partly a result of TWC's organizational design, is their relationship with the Gaston County Public School system. Gaston County Public Schools would be an ideal partner to raise awareness of the prevalence of mental or behavioral health issues that adolescents are currently experiencing in the county, as well as the resources available to students. However, the school system does not currently allow the TWC to conduct educational programs or post flyers within county schools because the TWC's mission does not align with the health curriculum of the school system (e.g., the school system primarily emphasizes abstinence-until-marriage, while the TWC distributes and prescribes contraceptives within their clinic).

Relationship-building with the Gaston County Public School system administration to create an appropriate educational campaign that meets the limitations set forth by the school system while educating students and building awareness of the TWC is an important step in the process of integration. Without support from the school system, integrating services (and all that it entails) may not see a significant return on investment.

Other connections within the community could assist in gaining support for integrated services within the TWC. For instance, relationships with other health care groups, health cooperatives or community groups could increase support of integration within the TWC. Partner organizations could also help disseminate information and encourage adolescents to visit the TWC for behavioral, reproductive and primary care services. Current participants in the ICARE

partnership, who provide integrated services and support integration overall, would likely be community supporters.

At the policy level, there is a lot of support for integration of behavioral health services through ACA initiatives and the North Carolina Foundation for Advanced Health Programs. Funding may be available through ACA legislation for advancement in provision of behavioral health and integrate services. If funding is not available through an ACA state grant, it could impact the level at which TWC is able to integrate services. For instance, with little to no additional funding, the TWC could engage in basic collaboration with a separate mental health provider or group of providers. However, funding needs would be more significant to engage in higher levels of integration that require hiring additional providers and subsequent billings and claims or scheduling professionals.

Applicability to Other Community Health Centers

Benefits to integration are increased access to mental/behavioral health services to the population served; improved coordination of physical and mental health services, which can reduce costs of over-utilizing health care services (e.g., emergency room, excess tests); and better clinical outcomes (World Health Organization, 2008). The ability to achieve the benefits of integration will likely be the same for health care facilities, if they exist in an area of demonstrated need for behavioral health services, such as Gaston County.

The main variance in realizing the benefits of integration would likely be due to the level of integration undertaken. For instance, those facilities pursuing minimal or basic collaboration in separate sites likely will not realize the same efficiency, cost and quality outcomes as those creating more fully-integrated services or systems. However, community health centers serving

areas with limited access to behavioral health services with the same level of integration should have similar benefits.

The barriers that the TWC faces are similar to those that are faced by other community health centers, such as those addressed by Manet Community Health Center, Quincy, M.A. and Tillamook Family Health Centers, Tillamook County, O.R., two community health centers that recently integrated behavioral health services (SAMHSA-HRSA, 2013). For instance, logistical and resource issues such as scheduling, billing and claims processing, and funding to support additional employees or non-employed mental health practitioners are common obstacles to integration for a wide range of provider group types. Additional barriers for the TWC include stakeholder approval and the nature of the patient population.

Since TWC is a state-funded clinic, it requires buy-in from a variety of city, county and state stakeholders that would not be required of a private medical group. Since the TWC provides care to minors, that adds an additional barrier because they have to account for parental/guardian consent for some types of treatment, upholding minors' rights laws, and more. As a consequence, the barriers faced by TWC are likely more difficult to surpass, though they do not differ in substance from other health centers. In that most community health centers are state or locally funded and provide care for similar socioeconomic demographics, the main difference would be the age of the population served and their specific behavioral health issues.

CHAPTER V

CONCLUSION

Summary

Behavioral health services, such as the counseling and treatment of mental health and substance abuse issues, are typically outsourced from primary care to mental health professionals; however, care is not coordinated between the referring and referred physicians. The Affordable Care Act and many state initiatives emphasize the need to improve coordination of health care and mental health services through various incentives, and the legislation stresses the importance of integrating behavioral health and primary care services in order to better manage population health and reduce health care spending.

Behavioral health integration has been shown to increase access to behavioral or mental health services, such as counseling and treatment for depression, substance abuse or other mental health disorders. In addition, integrated services naturally improve coordination of care between physicians for a single patient's health needs, which can result in improved health outcomes for the patient as well as cost savings (from potential decrease in overutilization of health care services and emergency care, or improper treatment) (World Health Organization, 2008).

The Teen Wellness Center (Gaston County, N.C.), a state-funded, adolescent-only community health center, aimed to determine the benefits and barriers to integrating behavioral health services into their currently offered services in June 2013. By reviewing community health assessment data and survey data collected by the TWC, county residents and, specifically, the adolescent population, a need for behavioral health services was evident. Research was conducted on types of integration, and the process of integration from external organizations and

health care leaders. This information provided the backdrop for understanding the barriers or obstacles that the TWC would face if they decided to move forward with integration, as well as some of the next steps.

After reviewing available guidance, lessons learned and research, it was determined that the TWC's patient population would benefit from integrated services and that reaching basic levels of integration would be feasible in the short term. The extent to which the TWC can offer fully integrated services is, however, a longer-term consideration that requires large stakeholder approval, and likely, a visible leader to champion the effort.

Recommendations

During the TWC's process of determining benefits and barriers of integration, a business plan was developed to outline steps within the process and issues that would need resolutions prior to moving forward. A recommended next step for TWC administrators is to disseminate the business plan to trusted stakeholders to get their opinions on whether integration seems viable. The TWC will need large stakeholder support to gain approval for close collaboration and/or full integration of services, since that involves additional resources being allocated to the center. Working with stakeholders from the beginning of this process to determine gaps in the business plan and to get their buy-in on the proposed next steps could help expedite the initiative.

The Teen Health Connection in Charlotte, N.C. could be a valuable resource, since the Teen Health Connection already went through the steps of integrating services and serves a similar adolescent patient population. The TWC should try to connect with administrators at the Teen Health Connection to glean specific lessons learned after integration and identify longer-term steps to take. Lastly, TWC administrators can start discussions with local mental health providers to whom they refer patients to determine willingness or interest in integration.

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APPENDIX

INTEGRATION PREPAREDNESS CHECKLIST

Access

- Is the Center accessible to teens throughout the county?
- Are there ways to build accessibility through a mobile health unit, telemedicine, or adding a stop to various bus routes?

Organizational Readiness

- Is there adequate buy-in from directors, county commissioners and the health department to develop the appropriate partnership to integrate?
- What level of integration is the most feasible and desirable for the TWC?
- What type of mental health professional would be the best fit for TWC, if they hire their own part-time or full-time employee to meet their integration needs?
 - Other case studies of community health centers that have integrated behavioral health services note that the type of mental/behavioral health practitioner hired or aligned for integration may vary. Case studies have used licensed clinical social workers (LCSW), licensed mental health counselors (LMHC), and psychologists. The appropriate practitioner or group of practitioners should be determined prior to integration of additional services, so that continuity of staff can be maintained.

Funding

- Does the TWC qualify for grant funding for integrating services? If so, is someone available to submit grants? Will grant funding need to be procured prior to integrating services?
- Can current funding be extended to include behavioral health services? Are current funding methodologies sufficient for including additional services?

Privacy and Confidentiality

- Does the TWC have staff capacity to work with an influx of parents or guardians? (Treating mental health requires parental signature, meaning more parents may come to the Center with their teens.)

Billings/Claims

- Depending on the level of integration (whether the Center is serviced by a behavioral health professional several days during the week; a behavioral health professional works full-time at the Center; a behavioral health group becomes affiliated with the TWC), there will be added complexity to the billing and claims process. TWC currently accepts all

private insurance, Medicaid and self-pay. The TWC has its own billing and claims department that may be able to handle the complexity added.

Technology

- If TWC decides to integrate behavioral health services, and it decides not to have behavioral health practitioners embedded in the actual Center (but part of a referral process or affiliated network), there should be some consideration given to electronic medical records (EMRs). There are ways to integrate disparate EMR systems through other advanced technology, but if one or both organizations already have an EMR set-up, this may be a consideration before moving forward.

Source: Sutton (2013)